
HOUSE BILL No. 1572

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-15; IC 34-30-2-44.5.

Synopsis: Medicaid managed care. Requires the office of Medicaid policy and planning (office) to expedite the review of an infant's placement and determine under certain circumstances that the infant is at a level of institutionalization that would qualify the infant for federal Supplemental Security Income. Requires each managed care organization that contracts with the office to provide services under the Medicaid program to: (1) have one uniform prescription drug formulary; (2) have one standard definition for specified terms; and (3) have one standard procedure for credentialing and claims processing. Requires payment for services under the Medicaid program in a hospital setting to be based on the individual's presenting symptoms and the services required to triage, diagnose, and treat the individual. Prohibits the denial of payment for services that are medically necessary solely because the provider did not obtain prior authorization in a timely manner.

Effective: Upon passage; July 1, 2009.

Welch, Brown C

January 16, 2009, read first time and referred to Committee on Public Health.

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Introduced

First Regular Session 116th General Assembly (2009)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2008 Regular Session of the General Assembly.

HOUSE BILL No. 1572

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 12-15-2-26 IS ADDED TO THE INDIANA CODE
2 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE
3 UPON PASSAGE]: **Sec. 26. (a) If an infant:**

4 **(1) is a patient in, or is anticipated to need care in, a neonatal**
5 **or perinatal intensive care setting for at least thirty (30) days;**

6 **or**

7 **(2) has an illness that falls in the diagnosis-related group**
8 **(DRG) category list used by the office that would qualify the**
9 **infant as disabled;**

10 **the office shall expedite review of the infant's placement and**
11 **determine that the infant is at a level of institutionalization that**
12 **would qualify the child for federal Supplemental Security Income.**

13 **(b) The office shall publish on the office's web site the**
14 **diagnosis-related group (DRG) category list used by the office in**
15 **subsection (a).**

16 SECTION 2. IC 12-15-12-4.5, AS ADDED BY P.L.101-2005,
17 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

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UPON PASSAGE]: Sec. 4.5. **(a)** A managed care provider's contract or provider agreement with the office ~~may~~ **shall** include a prescription drug program, subject to IC 12-15-5-5, IC 12-15-35, and IC 12-15-35.5.

(b) Beginning January 1, 2010, each managed care provider shall use one (1) uniform prescription drug formulary. The prescription drug formulary is not required to be the same as the drug utilization review board's preferred drug list established by IC 12-15-35 unless the managed care providers cannot agree on a uniform prescription drug formulary.

SECTION 3. IC 12-15-12-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 6. (a) A Medicaid recipient may be admitted to a hospital by a physician other than the recipient's managed care provider if the recipient requires immediate medical treatment.

(b) The admitting physician shall notify the recipient's managed care provider of the recipient's admission not more than forty-eight (48) hours after the recipient's admission.

(c) Payment for services provided to a recipient **who presents or is** admitted to a hospital under this section shall be made:

(1) based on the recipient's presenting symptoms and the services required to appropriately triage, diagnose, and treat the recipient as required under federal law; and

(2) ~~only~~ for services that the office or the contractor under IC 12-15-30 determines were medically reasonable and necessary.

(d) The office or a managed care organization that has contracted with the office to provide coverage for Medicaid recipients shall reimburse the following as follows:

(1) A physician, at:

(A) a rate of one hundred percent (100%) of rates payable under the Medicaid fee structure; or

(B) a contractually agreed upon rate between the physician and the managed care organization;

for professional emergency physician screening services provided under current procedural terminology (CPT) codes 99281 through 99283.

(2) A hospital, for all medically necessary screening services provided to an individual who presents to the emergency department with symptoms that may be an emergency medical condition.

(e) The office or a managed care organization may not do the following:

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(1) Determine what constitutes an emergency on the basis of lists of diagnoses or symptoms.

(2) Deny payment for a treatment provided when an individual has an emergency medical condition, even if the outcome, in the absence of immediate medical attention, would not have been an outcome specified in the definition of an emergency medical condition.

(f) The office may adopt rules under IC 4-22-2 to provide reimbursement for screening services provided in an emergency department of a hospital licensed under IC 16-21 that are not a covered service as of January 1, 2009.

(g) The office or a contractor under IC 12-15-30 may not refuse payment for services that are medically necessary on the sole basis that the provider did not obtain prior authorization in a timely manner.

(h) The office shall apply for an amendment to the state Medicaid plan if an amendment is necessary to carry out the requirements of this section.

SECTION 4. IC 12-15-12-13.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 13.5. (a) A managed care organization that has contracted with the office under IC 12-15-30 must have the following:

(1) A uniform definition of the following terms:

- (A) "Administrative denial".
- (B) "Appeal".
- (C) "Complaint".
- (D) "Grievance".
- (E) "Inquiry".
- (F) "Medical necessity denial".
- (G) "Reconsideration".

(2) A uniform procedure for the following:

- (A) Credentialing that allows a provider to be credentialed one (1) time for participation in any Medicaid program.
- (B) Claims processing.

(b) The office shall develop the following forms and require that each managed care organization that contracts with the office to use the forms:

- (1) A denial of a claim form.
- (2) An appeals process form.
- (3) Prior authorization form.

(c) A managed care organization may not change or otherwise

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reclassify a request made by a provider, including a request for an appeal, unless the provider agrees to the reclassification.

SECTION 5. IC 12-15-35-46 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 46. ~~(a)~~ This section applies to a managed care organization that enters into an initial contract with the office to be a Medicaid managed care organization after May 13, 1999.

~~(b)~~ **(a)** Before a Medicaid managed care organization described in subsection (a) implements a formulary **described in IC 12-15-12-4.5 may be implemented**, the managed care organization ~~shall submit the~~ formulary **shall be submitted** to the office at least thirty-five (35) days before the date that the managed care organization ~~implements the~~ formulary **is to be implemented** for Medicaid recipients.

~~(c)~~ **(b)** The office shall forward the formulary to the board for the board's review and recommendation.

~~(d)~~ **(c)** The office shall provide at least thirty (30) days notification to the public that the board will review ~~a~~ **the** Medicaid managed care ~~organization's organizations'~~ proposed formulary at a particular board meeting. The notification shall contain the following information:

- (1) A statement of the date, time, and place at which the board meeting will be convened.
- (2) A general description of the subject matter of the board meeting.
- (3) An explanation of how a copy of the formulary to be discussed may be obtained.

The board shall meet to review the formulary at least thirty (30) days but not more than sixty (60) days after the notification.

~~(e)~~ **(d)** In reviewing the formulary, the board shall do the following:

- (1) Make a determination, after considering evidence and credible information provided to the board by the office and the public, that the use of the formulary will not:
 - (A) impede the quality of patient care in the Medicaid program; or
 - (B) increase costs in other parts of the Medicaid program, including hospital costs and physician costs.
- (2) Make a determination that:
 - (A) there is access to at least two (2) alternative drugs within each therapeutic classification, if available, on the formulary;
 - (B) a process is in place through which a Medicaid member has access to medically necessary drugs; and
 - (C) the managed care organization otherwise meets the requirements of IC 27-13-38.

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(f) (e) The board shall consider:

- (1) health economic data;
- (2) cost data; and
- (3) the use of formularies in the non-Medicaid markets;

in developing its recommendation to the office.

(g) (f) Within thirty (30) days after the board meeting, the board shall make a recommendation to the office regarding whether the proposed formulary should be approved, disapproved, or modified.

(h) (g) The office shall rely significantly on the clinical expertise of the board. If the office does not agree with the recommendations of the board, the office shall, at a public meeting, discuss the disagreement with the board and present any additional information to the board for the board's consideration. The board's consideration of additional information must be conducted at a public meeting.

(i) (h) Based on the final recommendations of the board, the office shall approve, disapprove, or require modifications to the Medicaid managed care ~~organization's~~ **organizations'** proposed formulary. The office shall notify the managed care ~~organization~~ **organizations** of the office's decision within fifteen (15) days ~~of~~ **after** receiving the board's final recommendation.

(j) (i) The managed care ~~organization~~ **organizations** must comply with the office's decision within sixty (60) days after receiving notice of the office's decision.

(k) (j) Notwithstanding the other provisions of this section, the office may temporarily approve ~~a~~ **the** Medicaid managed care ~~organization's~~ **organizations'** proposed formulary pending a final recommendation from the board.

SECTION 6. IC 12-15-35-47 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 47. (a) This section applies to the following changes to ~~a~~ **the** formulary used by ~~a~~ Medicaid managed care ~~organization~~ **organizations** for Medicaid recipients:

- (1) Removing one (1) or more drugs from the formulary.
- (2) Placing new restrictions on one (1) or more drugs on the formulary.

(b) Before ~~a~~ **the** Medicaid managed care ~~organization~~ **organizations'** formulary described in subsection (a) ~~may be changed~~, the **proposed changes to the** managed care ~~organization~~ **organizations'** formulary shall ~~submit the proposed change be submitted~~ to the office.

(c) The office shall forward the proposed change to the board for the board's review and recommendation.

(d) The office shall provide at least thirty (30) days notification to

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the public that the board will:

(1) review the proposed change; and

(2) consider evidence and credible information provided to the board;

at the board's regular board meeting before making a recommendation to the office regarding whether the proposed change should be approved or disapproved.

(e) Based on the final recommendation of the board, the office may approve or disapprove the proposed change. If a proposed change is not disapproved within ninety (90) days after the date the managed care ~~organization submits the~~ **organizations'** proposed ~~change formulary changes are submitted~~ to the office, the managed care ~~organization~~ **organizations** may implement the change to the formulary.

(f) ~~★ The Medicaid managed care organization;~~ **organizations:**

(1) may add a drug to the managed care ~~organization's~~ **organizations'** formulary without the approval of the office; and

(2) shall notify the office of any addition to the managed care ~~organization's~~ **organizations'** formulary within thirty (30) days after making the addition.

SECTION 7. [EFFECTIVE UPON PASSAGE] (a) **As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) **The office shall apply to the federal United States Department of Health and Human Services for any amendment to the state Medicaid plan or for any waiver that is necessary to implement this act.**

(c) **The office may not implement the state plan amendment or the waiver applied for under this SECTION until the office files an affidavit with the governor attesting that the state plan amendment or waiver applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the waiver is approved.**

(d) **If the office receives a state plan amendment or a waiver under this SECTION from the United States Department of Health and Human Services and the governor receives the affidavit filed under subsection (c), the office shall implement the state plan amendment or the waiver not more than sixty (60) days after the governor receives the affidavit.**

(e) **The office may adopt rules under IC 4-22-2 necessary to implement this SECTION.**

(f) **This SECTION expires December 31, 2010.**

SECTION 8. **An emergency is declared for this act.**

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